VERMONT

AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

September 19, 2012

Judy Peterson, Director
Visiting Nurse Association
1110 Prim Road
Colchester, VT 05446

Provider ID #:477000

Dear Ms. Peterson:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **August 9, 2012**.

Follow up may occur to verify that substantial compliance has been achieved and maintained.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	477000	A. BUILDING _____ B. WING _____	C 08/09/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
VISITING NURSE ASSOCIATION	1110 PRIM ROAD COLCHESTER, VT 05446

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
G 000	INITIAL COMMENTS An unannounced onsite complaint investigation was conducted on 7/5/12 and completed on 8/9/12 after off-site review by the Division of Licensing & Protection. There were Federal regulatory violations related to this complaint survey.	G 000	*Care in accordance with plan of care G170* 1. Complete a review of Adult Home Care clients to determine the extent of the problem with visits not being made within the required frequency. Responsibility: Michael Garrett, Manager Quality & Education	9-12-12
G 170	484.30 SKILLED NURSING SERVICES The HHA furnishes skilled nursing services in accordance with the plan of care. This STANDARD is not met as evidenced by: Based on record review and staff interview, the agency failed to provide skilled nursing services in accordance with the Plan of Care for 1 patient in the applicable sample. (Patient # 1) Findings include: Per record review on 7/5/12 for Resident # 1 a patient with multiple co-morbidities including bilateral lower leg edema, had a 485/ Plan of Care with physician orders with a start date on 5/8/12 for: 'SN 1 every other week 9'. (Skilled Nursing Services one nursing visit every other week for 9 weeks) Per review of the skilled nursing visits made for Patient # 1, there was a PRN (extra/as necessary) skilled nursing visit made on 6/4/12 for Patient # 1 for a problem that was unrelated to his/her foot edema. Per review no skilled nursing visit had been made since the 6/4/12 PRN visit and per the plan of care, a nursing visit was due between the dates of Sunday, June 17th through Sunday June 24, 2012, with no nursing visit made during this time period.	G 170	2. Evaluate the current process of scheduling nursing visits and develop recommendations for improvement that will reduce the chances of missed visits. Specifically review coordination and communication between the clinicians and schedulers, the process for assuring visit frequencies are met, and the rescheduling of visits. Responsibility: Michael Garrett, Manager Quality & Education 3. Educate staff about changes in scheduling process: Responsibility: Margaret Pickett, R.N., Adult Home Care Team Manager 4. Continue efforts to recruit additional clinical staff for Adult Home Care, including the use of travelers as an interim solution. Responsibility: Pat Donehower, R.N., VP of Clinical Services 5. Establish an audit system to verify these regulations are being met. Responsible: Michael Garrett, Manager Quality & Education	10-5-12 10-26-12 9-6-12 10-26-12

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Patricia S Donehower, RN | VP for Clinical Services | 9-6-12

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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G 170	Continued From page 1 Per interview with the home health aide on 7/5/12 at 9 A.M. who regularly provided personal care for this patient, s/he confirmed that they had spoken with the RN case manager twice, on June 20th and June 22, 2012 to update him/her regarding an increase in yellowish foot drainage which s/he had observed during the provision of personal care. The aide confirmed that s/he had been informed by the nurse case manager that there was a skilled nursing visit scheduled for this patient on 6/22/12. However, due to a change in the nurse case managers schedule, Resident # 1 did not have a skilled nursing visit on 6/22/12 as planned nor was the visit rescheduled. On 7/5/12 at 3:20 P.M. the nurse case manager confirmed that although s/he had planned a skilled nursing visit for Patient # 1 on 6/22/12, due to a change in the schedule, the nursing visit was not made. In addition. s/he failed to speak to a supervisor or scheduler to have the visit rescheduled (as soon as possible by another nurse) or to notify the physician of the missed visit. On 6/25/12 the patient was hospitalized for changes related to his/her foot condition.	G 170	G170 accept POC Dawn Chittenden RN	
G 176	484.30(a) DUTIES OF THE REGISTERED NURSE The registered nurse prepares clinical and progress notes, coordinates services, informs the physician and other personnel of changes in the patient's condition and needs. This STANDARD is not met as evidenced by:	G 176		

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G 176	Continued From page 2 Based on record review and staff interview, the agency staff nurse failed to coordinate services and to inform the physician of changes in condition and/or a missed nursing visit for 1 patient in the sample. (Patient # 1) Findings include: Per record review on 7/5/12,the nurse case manager failed to reschedule a planned skilled nursing visit that s/he was unable to make on 6/22/12 due to scheduling changes at the agency. In addition, s/he failed to notify the physician of the missed visit and that the aide (providing personal care to the patient) had reported on 2 occasions (6/20 & 6/22/12) that there was increase in yellowish foot drainage on both these dates. Per interview with the home health aide on 7/5/12 at 9 A.M. (who had been regularly caring for the patient) s/he confirmed that they had spoken with the RN case manager on 2 occasions, June 20th and June 22, 2012 to update him/her regarding the increase in yellowish foot drainage observed while providing personal care. The aide was informed by the nurse case manager that there was a skilled nursing visit scheduled for this patient on 6/22/12. However, due to schedule changes at the agency, and to the nurse case managers schedule for 6/22/12, a nursing visit was not made. On 7/5/12 at 3:20 P.M. per telephone interview with the nurse case manager, s/he confirmed that the aide had reported to him/her (verbally) on 2 occasions, 6/2012 & 6/22/12 that during personal care s/he had observed that Patient # 1's foot had an increase in yellow drainage and was 'not	G 176	*Coordination of Services – G176* 1. Complete a review of other Adult Home Care clients to determine the extent of the problem. Responsibility: Michael Garrett, Manager Quality & Education 2. Evaluate the current process of communication between clinicians, Licensed Nursing Assistants, and physicians regarding changes of condition and notification of physicians about missed visits and develop recommendations for improvement. Responsibility: Margaret Pickett, R.N., Adult Home Care Team Manager 3. Review recommendations and expectations about communication with all members of the inter-disciplinary teams. Responsibility: Margaret Pickett, R.N., Adult Home Care Team Manager 4. Establish an audit system to verify these regulations are being met. Responsibility: Michael Garrett, Manager Quality & Education	9-12-12 10-12-12 10-26-12 10-26-12

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G 176	Continued From page 3 looking better.' The case manager also confirmed that a skilled nursing visit had been planned for this patient on 6/22/12 however due to a change in his/her schedule the nursing visit was not made that the day. S/he also confirmed that s/he had not spoken to a supervisor to have the visit rescheduled and that the physician had not been notified of the missed visit and/or the increase in drainage noted by the aide. On 6/25/12 the patient was hospitalized for changes related to his/her foot condition.	G 176	G 176 Accept POC Dawn Chittenden RN	